

July 21, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0924-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 43 year-old female who sustained a work related injury on ___. The patient reported that she sustained a repetitive motion injury to her right shoulder and neck area. The diagnoses for this patient included cervical spondylosis and rotator cuff syndrome right shoulder. The patient has undergone an MRI on 12/2/95, 2/7/96 and 9/23/02. The patient has had EMG testing performed on 10/11/95. The patient has been treated with physical therapy and epidural steroid injections as well as undergone right shoulder surgery on 11/8/02. Post surgically the patient has been treated with in office post-surgical rehabilitation that included cardiovascular, strength training and range of motion exercises.

Requested Services

Work Hardening Program 5 times a week for 6 weeks.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ____ chiropractor reviewer noted that this case concerns a 43 year-old female who sustained a work related injury to her right shoulder and neck area on _____. The ____ chiropractor reviewer also noted that the diagnoses for this patient included cervical spondylosis and rotator cuff syndrome right shoulder. The ____ chiropractor reviewer further noted that the patient was treated with physical therapy, epidural steroid injections and right shoulder surgery followed by post surgical rehabilitation. The ____ chiropractor reviewer indicated that the patient was treated with 4 weeks of post surgical rehabilitation. The ____ chiropractor reviewer also indicated that the patient made good progress with the surgery and the post surgical therapy. However, the ____ chiropractor reviewer also indicated that the patient could continue the therapy at home. Therefore, the ____ chiropractor consultant concluded that the requested work hardening program 5 times a week for 6 weeks is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 22nd day of July 2003.